Zoellner
CHIROPRACTIC

1

APPLICATION FOR TREATMENT

Case_____

Date_____

Patient_____

Address_____

_____
City State Zip

Phone (H)_____ (W)_____

Cell_____ Email_____

Best time and place to reach you_____
May we leave a medical message at home? ❑ Yes ❑ No
May we leave a medical message at work? ❑ Yes ❑ No
May we leave a medical message on cell? ❑ Yes ❑ No

Sex: ❑ M ❑ F Age_____ Birthdate_____

❑Single ❑Married ❑Widowed ❑Separated ❑Divorced

❑ Right-handed ❑ Left-handed ❑ Ambidextrous

Name & Age of Children_____

_____

Native Language_____

Patient SS#_____

❑ Employed ❑ Full-time student ❑ Part-time student

Occupation_____

Employer/School_____

Employer/School Address_____

_____

Whom may we thank for referring you?_____

_____

Where have you heard or seen us?
❑ TV ❑ Radio ❑ Billboard ❑ Magazine ❑ Flyer
❑ Yellow Pages –Tulsa ❑ Yellow Pages –Broken Arrow
❑ Health Fair

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Spouse's Name_____

Spouse's Birthdate_____

Spouse's Occupation_____

Spouse's Employer_____

Spouse's Phone (if different)_____

3

IN CASE OF EMERGENCY, CONTACT

❑ Spouse OR contact:

Name_____ Relationship_____

Phone (H)_____ (W)_____

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CONSENT & POLICIES

1) I understand and agree to allow Zoellner Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care.

2) I hereby authorize Zoellner Chiropractic including Dr. Charles Zoellner and his assigns to examine, test, x-ray, and administer treatment to me as they deem necessary.

3) I understand that all first visit charges are payable when services are rendered.

4) I realize that the fee paid for x-rays is for technical and professional charges only. The x-ray films themselves are the property of this office. Copies can be made if necessary for a fee.

5) I will be taking care of today's charges by:
❑ Cash ❑ Check ❑ Credit Card ❑ Voucher
❑ Auto insurance assignment

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Date

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CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize Zoellner Chiropractic including Dr.Charles Zoellner and his assigns to examine, test, x-ray, and administer treatment as they deem necessary to my child _____. This is to serve as long-term authorization and is to apply to all occasions of service until it is revoked in writing.

_____ _____
Guardian's Signature Authorizing Care Date

_____ _____
Witness Signature Date

Zoellner Chiropractic | 4785 East 91st Street, Suite-B | Tulsa,OK 74137 | (918) 488-8600

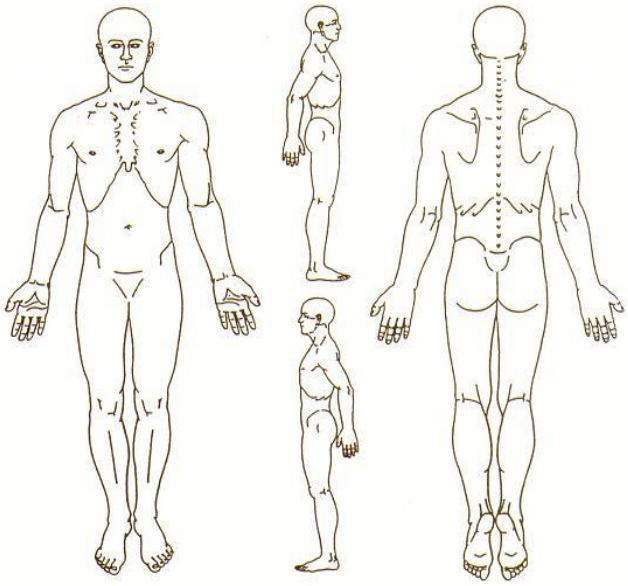
Patient_____ Case_____ Date_____

UNWANTED HEALTH CONDITION(S): Check any problems you might be having. Circle **L** if it is left or **R** if it is right,
Constant (75-100%) **F**requent (50-75%) **I**ntermittent (25-50%) **O**ccasional (0-25%),
0 = no pain **10**= worst possible pain

❑ Head	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Neck	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Shoulder: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Elbow: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Wrist: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Mid Back	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Low Back	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Hip: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Knee: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Ankle: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Other_____	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Other_____	C F I O	0 1 2 3 4 5 6 7 8 9 10

Mark all problem areas

Numbness OOOOO
Pins&Needles -----
Burning XXXXX
Aching *****
Stabbing /////



1. How would you describe your Chief Condition?_____

2. When did your Condition start bothering you?_____ Was it ❑ Gradual ❑ Sudden

3. What started your Condition?_____

4. Is Condition related to ❑ Work Injury ❑ Auto Accident ❑ Home Injury ❑ Fall ❑ Other:_____

4. What makes it better?_____ worse?_____

5. Which time of day is harder for you? ❑ In Bed – AM ❑ Morning ❑ Noon ❑ Evening ❑ In Bed – PM ❑ Sporadic ❑ All

6. Is your Condition: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numb ❑ Aching ❑ Shooting ❑ Burning ❑ Stabbing ❑ Tingling ❑ Cramping ❑ Stiff ❑ Swelling ❑ Deep ❑ Superficial ❑ Upon Movement ❑ Upon Touch

7. Does it radiate into an extremity? ❑ Yes ❑ No

8. Does your Condition interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation
Have you lost workdays? ❑ Yes ❑ No If yes, how many?_____
Have you had a similar condition before? ❑ Yes ❑ No If yes, when?_____
Activities that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

Name other doctors/clinicians/therapists/hospitals you have seen for this condition_____
Who is your current medical doctor?_____ dentist?_____
optometrist?_____ podiatrist?_____ massage therapist?_____
May we send an initial report to these health care providers? ❑ Yes ❑ No _____
Signature

Previous Chiropractic Care? ❑ Yes ❑ No Were you given a spinal hygiene/maintenance program? ❑ Yes ❑ No
What did you like?_____ What did you not like?_____

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Patient_____ Case_____ Date_____

DISEASES: Mark any of the following you have had:

❑ Pneumonia	❑ Measles	❑ Heart Disease	❑ Mental Disorders
❑ Rheumatic Fever	❑ Mumps	❑ Thyroid – High/Low	❑ Lumbago
❑ Polio	❑ Small Pox	❑ Influenza	❑ Eczema
❑ Tuberculosis	❑ Chicken Pox	❑ Pleurisy	❑ AIDS, HIV
❑ Whooping Cough	❑ Diabetes – Type:_____	❑ Arthritis – Type:_____	❑ _____
❑ Anemia	❑ Cancer – Type:_____	❑ Epilepsy	❑ _____

REVIEW OF SYSTEMS: Mark any of the following you have had in the past 6 months:

MUSCULOSKELETAL
- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficulty Chewing/Jaw Click
- ❑ General Stiffness

NERVOUS SYSTEM
- ❑ Nervous
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion/Depression
- ❑ Fainting
- Convulsions
- ❑ Cold/Tingling Extremities
- ❑ Stress

GENERAL
- ❑ Fatigue
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

GASTROINTESTINAL
- ❑ Poor/Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Weight Trouble
- ❑ Abdominal Cramps
- ❑ Gas/Bloating After Meals
- ❑ Heart Burn
- ❑ Black/Bloody Stool
- ❑ Colitis

GENITOURINARY
- ❑ Bladder Trouble
- ❑ Painful/Excessive Urination
- ❑ Discolored Urine

C-V-R
- ❑ Chest Pain
- ❑ Short Breath
- ❑ Blood Pressure Problems
- ❑ Irregular Heartbeat
- ❑ Heart Problems
- ❑ Lung Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling
- ❑ Stroke

EENT
- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Ear Aches
- ❑ Hearing Difficulty
- ❑ Stuffed Nose

MALES
- ❑ Prostate/Sexual Dys.
- ❑ Breast Pain/Lumps

FEMALES
- ❑ Menstrual Irregularity
- ❑ Menstrual Cramps
- ❑ Breast Pain/Lumps

Last Period?_____

Pregnant? ❑ Yes ❑ No

FAMILY HISTORY: Mark if family such as grandparents, parents, siblings, or children have had any of the following:

❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Thyroid Disease ❑ Kidney Disease ❑ Migraines ❑ Spinal Disorder

_____

_____

EXERCISE: ❑ None ❑ Moderate ❑ Daily ❑ Heavy **WORK HABITS**: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

HABITS: ❑ Smoking, Packs/Day_____ ❑ Alcohol, Drinks/Week_____ ❑ Coffee, Cups/Day_____ ❑ Sugar

❑ High Stress Level Reason_____ Hobbies/Activities/Interests_____

INJURIES/SURGERIES you have had Description (write the **date** in parentheses for each)

Auto Accidents _____

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

Implants/Replacements_____

MEDICATIONS: _____

_____

ALLERGIES: _____

VITAMINS/HERBS/MINERALS:_____

I am interested in seeing the following financial agreements:

❑ Time of Service ❑ 17 and under/Student ❑ 65 and over/Disabled ❑ Employee/Independent Contractor